Texas Department of Insurance, Division of Workers' Compensation
7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1609

MEDICAL DISPUTE RESOLUTION FINDINGS AND DECISION

PART I: GENERAL INFORMATION

Requestor's Name and Address: Glenn J. Bricken, Psy. D. 25810 Oak Ridge Drive The Woodlands, TX 77380	MDR Tracking #.: M4-07-3000-01 Claim #: Injured Employee's Name:
Respondent's Name and Box #: TEXAS MUTUAL INSURANCE CO. REP BOX # : 54	Date of Injury: Employer's Name: Trio Electric Ltd. Insurance Carrier's #: 99F0000406074

PART II: REQUESTOR'S PRINCIPLE DOCUMENTATION AND POSITION SUMMARY

Requestor's Position Summary states, "We are requesting a review of this claim for our client Dr. Glenn J. Bricken, Licensed Psychologist. On 2-9-2006, Dr. Bricken performed a full Psychological Evaluation with patient [injured worker]. The carrier paid for one (1) hour of the diagnostic interview (90801) but failed to pay for the review of records, (90885) case management (90887), and Narrative report(99080). We will only be entering the latter (99080) into this dispute as we feel that there is a strong precedent for the payment of this procedure. The carrier denied the report for code "CAC-97 Payment is included in the allowance for another procedure."

Principle Documentation:
1. DWC 60 package
2. CMS 1500's
3. Medical Reports

PART III: RESPONDENT'S PRINCIPLE DOCUMENTATION AND POSITION SUMMARY

Respondent's Position Summary states, "Texas Mutual applied Medicare's position concerning code 99080, which states in part "…Status indicators determine if Medicare can consider the code for payment. The indicators that preclude payment are: Indicator B." Medicare goes on to state the description of Status Indicator B is"…Payment for covered services are always bundled into payment for other services not specified. There will be no RVUs or payment amounts for these codes and no separate payment is ever made. (Example: CPT code 99070, which is for supplies, has a .B. status and no code with a .B. status is even reimbursed as a separate charge.) The following codes have been designed to have a .B. status and will not be reimbursed as a separate charge." (Exhibit 2) A long list of codes is given one of which is 99080."

Principle Documentation:
1. Position Summary
2. DWC 60 package

PART IV: SUMMARY OF DISPUTE AND FINDINGS

Date(s) of Service	Denial Code	CPT Code(s) or Description	Part V Reference	Additional Amount Due (if any)
02/09/2006	97, 217, 284/W4, 891	99080-N-4	1-4	$0.00
TOTAL DUE				$0.00

PART V: MEDICAL DISPUTE RESOLUTION REVIEW SUMMARY, METHODOLOGY, AND/OR EXPLANATION

Section 413.011(a-d) titled *Guidelines and Medical Policies*, and Division Rule 134.202 titled *Medical Fee Guideline* effective August 1, 2003, sets out reimbursement guidelines.

1. This dispute relates to procedure/service that was billed under CPT code 99080-N4 for DOS 02/09/2006.

2. Per Rule 133.307(d), the request for medical dispute resolution was received in the Division on 01/12/2007.

3. Based on Division Rule 133.307(d)(1-2), the only date of service eligible for review is 02/09/2006.

4. CPT code 99080-N-4 is defined as special reports such as insurance forms, more than the information conveyed in the usual medical communications or standard reporting form. The insurance carrier denied reimbursement initially based upon, "CAC-97- payment is included in the allowance for another service/procedure.", "217 – The value of this procedure is included in the value of another procedure performed on this date." and "284 - No allowance was recommended as the procedure indicates a status B (bundled) based on Medicare." After reconsideration The insurance carrier denied reimbursement based upon, "W4-No additional reimbursement allowed after review of appeal/reconsideration." and "891-The insurance company is reducing or denying payment after reconsidering a bill." Per Rule 134.202, narrative reports are not global and may be reimbursed. A review of the CMS-1500 indicates that the Requestor utilized modifier "N-4"; this modifier is not contained in Rule 134.202. A narrative report is defined in Rule 133.106(e) as "…original documents explaining the assessment, diagnosis, and plan of treatment for an injured employee written or orally transcribed. Narrative reports shall provide information beyond that required by prescribed report forms. The narrative reports should be no more than double-spaced on letter size paper. Clinical or progress notes do not constitute a narrative report." The Requestor submitted the Confidential Psychological Evaluation report to support billing. The report of the Confidential Psychological Evaluation is global to that service. The Requestor did not submit a separate narrative report to support billing; therefore, no reimbursement is recommended.

Therefore it is the conclusion of the Medical Dispute Resolution that reimbursement is not due the Requestor.

PART VI: GENERAL PAYMENT POLICIES/REFERENCES IMPACTING DECISION

Texas Labor Code 413.011(a-d)
28 Texas Administrative Code Sec. §134.1
28 Texas Administrative Code Sec. §134.202

PART VII: DIVISION DECISION

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code, Sec. 413.031, the Division has determined that the Requestor is not entitled to reimbursement.

Decision by:

		05/30/07
Authorized Signature	Medical Fee Dispute Resolution Officer	Date

PART VIII: YOUR RIGHT TO REQUEST JUDICIAL REVIEW

Appeals of medical dispute resolution decisions and orders are procedurally made directly to a district court in Travis County [see Texas Labor Code, Sec. 413.031(k), as amended and effective Sept. 1, 2005]. An appeal to District Court must be filed not later than 30 days after the date on which the decision that is the subject of the appeal is final and appealable. The Division is not considered a party to the appeal.

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.